Cost-of-Public-Health Model Update: October 25, 2002

What We Heard from WSALPHO Forums/Groups

Overall:

- A useful communication tool.
- National standards must exist to be able to help with staffing ratios.
- Health status/conditions should be the population driver of need for staff.
- Assumptions behind cost drivers and indirect costs (e.g. a judgment call, mid-point among a sample of LHJs) must be documented well in the final presentation.
- The system consists of more than LHJs. Include community partners.

EH Directors:

- Where are the minimums for small counties?
- This needs to be based on some standard/effort that already exists for it to be credible
- Some of the measures are very program-based – directors would like to restructure EH activities according to data used for the standards assessment to be more population-based. Larry Fay is leading effort – due late October.

PH Nursing Directors:

- Where are the minimums for small counties? What about border counties, geographically spread out areas, very small areas?
- Are there best-practice, NACCHO, national data for staffing levels or business standards that can be used? (Example: clerical staff per professional in clinical professional care.)
- In some cases there is minimum staff plus surge response needed.
- Need a better descriptor for "optional" services since the majority of public health nursing activities and cost drivers fall in this category. Concern that by placing many categorically-funded activities into "helping people get the services they need" places services in jeopardy.
- Can the type of FTE be broken out into better categories (sanitarian, PH nurse, assessment coordinator)?
- Reviewed activities under-represented in the model, including: tobacco, CSHCN, CD outbreak response, WIC, Child Death Review, early intervention, injury prevention, nutrition & chronic conditions (breastfeeding, obesity), seniors (access to care, screening, injury prevention), parent & child health (SIDS), oral health, child care, First Steps and OLDS, case management split out by type (HIV, CPS, MSS, MCH, CSHCN), family planning education and outreach. Encouraged development of drivers for each.

PHELF

- NACCHO must have public health professionals per population work done.
- Needs to be based on existing standards, but don't sacrifice the good for the perfect.
- Focus on "regionalizing" services is not about governance but efficient "joint ventures."

Assessment Coordinators

- We seem to have captured the Epi portion of work, but not community mobilization activities. Reduced Epi driver to 0.5 FTE:jurisdiction and 1:75,000 population thereafter and added 0.5 FTE:jurisdiction and 1:50,000 population thereafter for "Health Planning, Implementation and Evaluation." Achieves an adequate staffing level in most jurisdictions with this approach.
- Need clarification: How is there skill or program overlap with assessment activities and the first measure listed in the Prevention/Promotion category?
- Will draft activity descriptions to clarify what is meant by these activities.
- Move clinician role of Health Officer to "Helping People Get the Services They Need."
- Community consortia/collaborations are not accounted for in the model
- Be careful about presentation. Drivers seem to drive costs very high and Legislature would tell us to go home if they saw it. Must be viewed as "blue sky" exercise.
- Need to test how real this is – compare it to actuals.

DOH Managers

- Developed 4 DOH program "types:"
    - DOH, LHJs and others do some direct service, DOH consults
    - DOH in consultative role
        - LHJs provide direct service and DOH consults.
        - DOH provide no direct service but plays a consultative role. Service may be contracted to a non-LHJ entity (community partner, UW hospital, etc.)
    - DOH is sole direct service provider
    - DOH is primary coordinator and relies on local information with some contract or coordination needed
- Developed 7 DOH roles that exist in varying degrees in every program type: federal contacts, assurance, coordination, contract oversight, technical assistance, convener, planning. Depending on the role, the cost may be different.
- Explored how three DOH programs evolved over time: West Nile Virus project (vector), Breast and Cervical Health, and Immunizations.
- DOH 2002 strategic planning in 2002 includes a list of activities as aligned with the mission (may be able to organize this by standard).
- These three components will help us build a "prototype DOH program" by which DOH costs by program can be estimated.

What's Changed Based on Input:

- Revised/added Tobacco Prevention/Youth Access, First Steps/MSS/MCM Case Management, CSHCN Outreach, WIC, Injury Prevention, Child Death Review and Parent/Child Health (SIDS)
- Updated/increased salaries. Source is still Occupational Employment Statistics (OES) Data from Employment Security, January 2002 (see table)
- Revised cost drivers in "Understanding Health Issues" as above

- Bottom-line model output – cost of public health:

	June 28 version	October 25 update
State DOH costs*	$109 million	$124 million
Local costs	$569 million with; $398 million without "optional" services	$ 469 million with; $ 823 million without "optional" services
Total cost to provide PH	**$508-$678 million**	**$594-$947 million**

Still Pending to Complete the Baseline:

- Committee questions for 10/25:
    - Staffing minimums
    - Inflation factors for travel time
    - Tobacco – 1:75,000 is a guess – a better driver?
    - Driver for clinical lab services
- AIDS case management (Marty, Jack Jourden).
- New EH structure from EH Directors (Larry Fay).
- *The cost model understates DOH's current level of effort. Need to incorporate DOH managers' input about how DOH builds programs (Marty, Lois Speelman and DOH managers work group). One perspective: DOH's recommended biennial budget is $637.6 million (all funds). Even if we "discount" their budget by the amount of pass-through funding, the cost model total for DOH should be higher than $109 million.
- Incorporate additional input from Assessment Coordinators (Marty, Christie Spice).
- Address Prevention/Promotion drivers not yet in from Nursing Directors' group (Nancy Cherry and workgroup).